CITY OF RIVERSIDE
REQUEST FOR LEAVE FORM

EMPLOYEE INFORMATION: (To be completed by employee - fill out all information that applies)

Employee_____ Date_____
ID #_____ Dept./Div._____
Current Address_____
Position_____
Phone Number (Home)_____ Phone Number (Work)_____

DATES/HOURS OF LEAVE: (To be completed by employee - fill out all information that applies)

Date Leave to Begin_____ Expected Date of Return_____
Total Hours Requested_____ Intermittent Leave Requested* Yes_____ No_____
If less than a full day is requested, hours: *Attach requested schedule
From_____ To_____ From_____ To_____

TYPE OF LEAVE: (To be completed by employee - check appropriate boxes below)

PERSONAL LEAVE:		**MISC. LEAVE:** (Attach Military or Court Order)	
❑	Administrative Leave (Code 154 - GL 411292)	❑	Military Leave With Pay (Code 701 - GL 411230)
❑	Compensatory Time Off (Code 300 - GL 411130)	❑	Military Leave Without Pay (Code 702 - GL 411230)
❑	Vacation (Code 225 - GL 411210)	❑	Witness Appearance (Code 803 - GL 411100)
❑	Leave Without Pay/General (Code 107 - GL 411100) (Attach written request)	❑	Jury Duty (Code 700 - GL 411280)
❑	Other: (Specify)		

BEREAVEMENT LEAVE: (Attach documentation such as obituary, if requested by supervisor)

❑	Bereavement (Code 153 - GL 411260)	List Deceased Family Member Name and Relation to Employee:_____

SICK/FAMILY SICK LEAVE: (Short-term Non-Serious Health Condition)
(Attach Medical Certification from Health Care Provider - if leave is for more than three consecutive days)

❑	Sick Leave (Code 200 - GL 411240)	
❑	Family Sick Leave (Code 201 - GL 411245)	List Family Member Name and Relation to Employee:_____

FMLA SICK/FAMILY SICK LEAVE:* (Long Term Serious Health Condition)
(Completed Medical Certification must be submitted to Human Resources)

Indicate Reason for Request:
- ❑ Birth of a Child
- ❑ Placement of a Child for Adoption or Foster Care
- ❑ Serious Health Condition of the ❑ Spouse, ❑ Registered Domestic Partner, ❑ Child, or ❑ Parent of the Employee
- ❑ List Family Member Name and Relation to Employee:_____
- ❑ Serious Health Condition of the Employee
- ❑ Pregnancy Disability

❑	FMLA Sick Leave (Code 204 - GL 411240)	❑	FMLA Vacation (Code 227 - GL 411210)
❑	FMLA Family Sick Leave (Code 203 - GL 411245)	❑	FMLA Compensatory Time (Code 304 - GL 411130)
❑	FMLA Time Without Pay (Code 108 - GL 4111000)		

Approvals

Employee Signature_____ Date_____
Supervisor Signature _____ Date_____ ❑ Approved ❑ Denied *
Department Head Signature _____ Date_____ ❑ Approved ❑ Denied *
City Manager Signature _____ Date_____ ❑ Approved ❑ Denied *
Human Resources _____ Date_____ ❑ Approved ❑ Denied
Date of Verbal Notification:_____ Date of Written Notification:_____

*** For Family, Medical, and Pregnancy Disability Leave, contact Human Resources for approval within one day.**

Distribution: Employee, Department, Human Resources Form No. 1290.002 Rev.5/03 Benefits/LOAs/Forms/unileav1.frm